

**Community Service Network 6 Meeting
DoubleTree Hotel, Portland, Maine
December 15, 2006**

Approved Minutes

Members Present:

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| <ul style="list-style-type: none"> • David Bouthilette, AIN • Peter Driscoll, Amistad • Don Harden, Catholic Charities • Leslie Brancato, Community Counseling Center • Sherry Sabo, CSI • Susan Percy, Creative Work Systems • Phoebe Prosky, Freeport Counseling Center • Glenn Shelton, Goodwill Industries • Michelle Belhumeur, Gorham House • Sally Cloutier, Ingraham | <ul style="list-style-type: none"> • Mary Jane Krebs, MMC, Spring Harbor • Burma Wilkins, Mercy Hospital • Lois Skillings, Mid Coast Hospital • Christine McKenzie, MMC Voc Services • Jennifer Tingley Prince, NOE • Susan Boisvert, Parkview Adventist Med Center • Stephen Habeeb, PSL-Services • John Bradley, Preble Street • Jamie Morrill, Riverview Psychiatric Center • Catherine Snow, Spurwink/Portland Help Center | <ul style="list-style-type: none"> • Roger Wentworth, Sweetser • Charlotte Simpson, Sweetser Peer Center • Christine Holler, Transition Planning Group • Karen Evans, Transition Planning Group • Kelli Star Fox, Transitions Counseling • Nancy Ives, VOA • Andrea Paul, Youth Alternatives • Joe Brannigan, Shalom House Inc. • Amy Thomas, Smart Child & Family Service |
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Members Absent:

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| <ul style="list-style-type: none"> • Casco Bay Mental Health • Casco Bay Substance Abuse Resource Center • First Atlantic Corp • Food Addiction Chemical Dependency Consultants | <ul style="list-style-type: none"> • Healthy Perspectives • Gouzie Associates • Medical Care Development • New England Rehab Hospital of Portland | <ul style="list-style-type: none"> • Phoenix Mental Health Services • Regional Transportation Program, Inc. • Work Opportunities Unlimited |
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Others present:

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| <ul style="list-style-type: none"> • Laura Gottfried, Community Counseling Center • Peter Sentner, Catholic Charities • Kirk Little, Ingraham | <ul style="list-style-type: none"> • Joe Everett, Ingraham • Cindy Fagan, Sweetser | <ul style="list-style-type: none"> • Kristin Fortier, DHHS • Mary Tagney, DHHS |
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Staff present: DHHS/OAMHS: Ron Welch, Marya Faust, Don Chamberlain, Leticia Huttman, Carlton Lewis. Muskie School: Elaine Ecker, Anne Conners, Sally Ward.

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| I. Welcome and Introductions | Carlton Lewis, Region I Team Leader, welcomed everyone to the meeting. Introductions followed. |
| II. CSN Meeting Guidelines | Carlton referred everyone to the "CSN Meeting Guidelines" and asked for suggestions for changes or revisions. None were suggested. Question: How does one RSVP? Answer: By contacting Elaine Ecker at 626-5297 or eecker@usm.maine.edu . |
| III. Contract Amendments and Provider Agreements | Don Chamberlain reported that most OAMHS contracted providers have returned their contract amendments. He said that the following are outstanding: Casco Bay Substance Abuse Resource Council, First Atlantic Corp (Hawthorne House), Healthy Perspectives, Northeast Occupational Exchange, Smart Children and Family Services. A representative from Northeast Occupational Exchange said that its contract amendment was sent in to the Region III office. as that is where its headquarters are located. Don said that this was okay. A representative from Smart Children and Family Services said theirs was sent in two days ago. Don thanked people for getting their contract amendments in and said organizations that haven't will be reminded to do so. |

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| <p>IV. Memorandum of Understanding</p> | <p>Ron Welch said that two documents were left on the table at the last meeting: the MOU that was signed prior to January 3 and the agreement on operational protocols. He noted that there is considerable overlap between the two. He also said that the OAMHS clarified what it meant by a “no reject” policy via a memorandum that all should have received by now. A final draft of the MOU is due in two weeks. Once agencies receive the MOU, it should be signed by the corporate head.</p> <p>In response to feedback at other meetings, Ron said that OAMHS agrees that there is a need for more flexibility in who the voting designee is and that documents will be modified to reflect that.</p> <p>He asked if participants would like to add anything to the MOU:</p> <p>Question: What kind of legal entity is this? What liability will we have as a CSN member? Answer: OAMHS is committed to establishing the legal basis for the CSN in writing.</p> <p>Comment: Regret that outreach was not included as a core service. Response: Good point: The eight core services are those delineated in the approved Consent Decree Plan. Ron said that if people see issues not covered as a core service, they should identify these and translate them to legislative requests.</p> <p>Comment: Would like to see deaf services as having more integration with mental health services. Response: One way to achieve this is to continue to have this advocacy present at CSN meetings. Later in meeting will also discuss data collection for unmet needs.</p> <p>Point of clarification: Page 3 of MOU, Section V, Point B, Bullet Number 1: “Assure delivery of services to all mental health consumers in the network area.” Assume that inherent in this point is to the level of the ability of the organization and its licensure. Response: Yes, this point may be reflected in clarification that was sent out.</p> <p>Question: What is the definition of Adult Mental Health Consumer? Answer: Marya Faust will discuss that definition in her presentation.</p> <p>Comment: Critical to clarify authority of CSN and sharing of information early on. Response: OAMHS has asked for an opinion from the Attorney General’s office as to the boundary limits of confidentiality.</p> <p>Comment: MOU refers to all mental health consumers in network area, then there are those eligible under MaineCare, these aren’t the same. Response: We’re talking about the 10,000 people with serious mental illness whether class members or not, not talking about everyone who is receiving mental health services, though managed care is.</p> <p>The MOU, with the amendment recommendations discussed by the group, was accepted by a majority vote.</p> |
| <p>V. Operational Protocols</p> | <p>Ron Welch led a discussion on the operational protocols and whether they can be incorporated into the MOU.</p> <p>Question: Does clarification of an agency’s designee need to be added before adopting? Answer: Yes, and it will be.</p> |

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| | <p>Comment: The memo on clarification of “no reject” policy is not included in the packet and was not distributed prior to the meeting to those without email. Important for consumers and those who don’t have email to receive same information as others prior to the meeting.</p> <p>Response: OAMHS and Muskie are working to build an electronic list and a hard copy list so materials can be adequately distributed.</p> <p>The following was passed by a majority vote: Transfer and incorporate corresponding recommendations from the MOU into the Operational Protocols and to also distribute the no reject policy at the same time.</p> |
| <p>VI. Provider Services Data Matrix, Maps, Service Gaps</p> | <p>Marya explained that the data CSN members provided from the electronic data forms will be presented in two ways: (1) maps, for a visual picture of where services are delivered, (2) a data matrix, for comprehensive, in-depth written information. This effort is just beginning, she explained, and the data will continue to be gathered and refined.</p> <p>She showed PowerPoint slides representing the population density of Maine, and symbols (both town and county-wide) indicating where each core service is located/delivered (as reported in the data sheets through 12/4/06). The maps will continue to be developed to show more clearly where services are located/delivered and depict more about the depth and coverage areas.</p> <p>Members were asked to review the information in the matrix and provide any revisions or missing data to Elaine Ecker at the Muskie School: eecker@usm.maine.edu.</p> <p>Marya distributed a handout (2006 Profile) of data collected from MaineCare and from mental health services funded by the General Fund showing:</p> <ul style="list-style-type: none"> • 33,874 people are receiving mental health services • 10,129 of those have serious mental illness (43.3%) • 38% of the 10,129 have co-occurring disorders of mental illness and substance abuse • National Medicaid data shows people with serious mental illness live 25 years less • 69% have one or more other health conditions; 46% have two or more; 28% have three or more • 1 in 5 have diabetes, compared to 1 in 10 for MaineCare members with no mental illness <p>Marya said that this data has great implications for service planning, given the number of people with mental illness in MaineCare struggling with complex medical issues.</p> <p><u>Comments:</u></p> <ul style="list-style-type: none"> • The 10,129 figure is probably an undercount, as it won’t apply to those with categorical MaineCare who aren’t using mental health services or those who don’t apply for services. • Portland area would probably have the highest number of people who are not receiving services but would fall into these categories. • Those with serious mental illness come into the elder population category earlier, in mid-to early 50s, and wondered about the broad age category of 21-64. Marya said that the ranges are based on federal reporting categories, and then asked where the break should be. The member responded “at least 55, and arguments could be made for bringing it down further.” <p>Marya distributed a report showing the number of specific unmet needs of clients in CSN 6, as well as a sheet indicating the</p> |

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| | <p>number of clients in each CSN with unmet needs. The two sheets show that 201 clients have 416 unmet needs in CSN 6, Cumberland County. The client pool includes people receiving Community Integration, Intensive Community Integration, and Assertive Community Treatment services; mental health services through General Funds; and Consent Decree Class Members who request certain services through OAMHS directly.</p> <p>She explained this report will be generated every 90 days, and over time will provide valuable information about where needs continue to be unmet. She briefly explained the process of determining a need is “unmet,” i.e. that the particular service is not provided within a certain acceptable timeframe set by the Court. The information about needs comes from clients’ Individual Support Plans (updated every 90 days) as input by Community Support Workers, case managers, Consent Decree Coordinators, etc., into the RDS-EIS reporting system.</p> <p>The group engaged in a discussion of capturing unmet needs that are not captured in other ways, highlights as follows:</p> <ul style="list-style-type: none"> • There is no data on those who are not connected to services: building plans and services on beliefs that we are capturing the whole picture. • One way to capture unmet needs would be through the State’s 211 system. • Ron Welch commented that as a CSN, the group could form an ad hoc committee to collect data elements. He also commented that data on unmet needs presents an opportunity to prepare budgets for requests to the legislature. He said data is essential to discharge from court supervision, as well as the budget process, and needs to “see the light of day.” • Is there a mechanism to go back and identify gaps [beyond the eight core services]? Answer: We have to do at least the eight core services; there is nothing to prevent us from doing more once those are achieved. • Collaborate with other groups, such as organizations serving the homeless, on their data collection. Initial data collected by this group shows that following housing, the next biggest unmet need is mental health services. • A lot of discussion about outreach to those not being served; another area of outreach is for people we are working with who slip or disappear. Outreach now comes from ICIs, no outreach from community agencies because of lack of funding. Great loss. • To the extent that CSN has resources, useful to establish workgroup on unmet needs and bring forth data to full body. • Data work group could hopefully encompass more than unmet needs, could be a report card on the wellness of the system; also how providers are doing financially, as a business. • Should also consider the outreach that is necessary to the refugee and immigrant populations. • Consider Institute of Medicine’s latest report on mental illness as a consensus document that could shape policy. |
| VII. Vocational Services | <p>Don Chamberlain said that the department sees vocational services as both critical and under funded. Two initiatives are underway: 1) training of CSWs to identify vocational issues in goals and ISPs, with specific training in January and February with multiple sites via ITV and 2) hiring of Employment Specialists. Each CSN will have an Employment Specialist, with four being hired in this fiscal year and three more in the next fiscal year. It is possible that more than four may be able to be placed in this fiscal year. The Employment Specialists will be placed in community agencies, although clients will not have to be receiving services from that agency to access an Employment Specialist.</p> <p>He referred the group to the MOU between the Department of Labor/BRS and OAMHS. He explained that a workgroup will be convened and led by Jim Braddick and a representative from Voc Rehab to work on issues specified in the “Joint Responsibilities” section. Others are welcome to join the workgroup and, if interested, should contact Elaine Ecker at the Muskie School, eecker@usm.maine.edu.</p> |

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| | <p>He also referred to the group to the section on “Coordination of Services Between OAMHS Funded Employment Specialists and BRS VR Counselors.” He explained that when consumers become eligible for VR services (from the waiting list), they would have a choice of continuing to work with the Employment Specialist, with full access to resources available for VR clients. VR will accept any plan developed with the ES, if consumer chooses to obtain services through VR.</p> <p>Question: What resources could people access through Vocational Rehab? Answer: Voc Rehab counselors have budgets to work with for each client to help the client with their identified goal: ranging from starting a small business to acquiring the proper tools, a computer, clothes, etc.</p> <p>Question: What would be the focus of ES? Answer: Work with consumers around plan to help get person employed. Provide ongoing support in helping person retain that job.</p> <p>Question: What grants are available to mental health agencies to support vocational services? Answer: Employment Specialists are salaried position; won't require third party billing. MaineCare doesn't reimburse for this service.</p> <p>Don said if more people get identified as having employment in their ISP, they can get into see Employment Specialists or Vocational Rehab and a case can be built for the need for more vocational services. 15 percent of an ES caseload needs to reach competitive employment.</p> <p>Comment: A two-day training just completed for working with the homeless on Employment First Network model. Pilot project will be happening in Lewiston. Nancy Fritz is contact for more information.</p> <p>Question: How was the 15 percent goal around Employment Specialists set? Answer: Number set by DHHS Commissioner, based on her expertise and knowledge of the field.</p> <p>Don also distributed a Memorandum to clarify the role of ACT team employment specialists particularly in regard to the amount of work time devoted to vocational/employment services (90 percent) and the percentage of consumers placed in competitive settings (15 percent).</p> |
| VIII. Role of Consumers in Licensing | <p>Leticia Huttman said that OAMHS has been discussing the role of consumers in licensing with the Consumer Advisory Group. She said consumers are interested in whether services are: recovery-oriented, consumer-driven, person-oriented with a goal of helping the person live a productive life in the community. While this is hard to evaluate, consumers have been looking at using standardized tools like the Elements of a Recovery Facilitated Systems tool for interviewing individuals receiving services and staff members. This assessment should help consumers, providers, and OAMHS. Consumers who participated in this assessment process would be trained and compensated. Timeline for training spring/late spring.</p> <p>A discussion ensued on whether working with licensing is the ideal activity for consumers. Many of the elements in licensing are anti-recovery, participants noted, and said they wouldn't want the experience to start badly for consumers.</p> <p>Question: Are any other states modeling this? Answer: Other states have consumer teams; some states view this as part of QA.</p> |

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| | <p>Comment: Recovery-oriented processes and licensing regulations that are Medicaid driven are two separate processes. Gap between paperwork and what agencies actually do. How to meld?</p> <p>Comment: Not much progress made on “deemed status.” Would love to see that resolved. Licensing has role of looking at minimum licensing standards; start to get into best practices: don’t know that licensing is qualified for this. Response: Put “deemed status” in parking lot for now.</p> <p>Comment: Peer Centers might be a better place to start. Peer centers have standards, developed by peers, but have never been reviewed. Response: Good idea to look at these peer standards.</p> <p>Suggestion: Consumers should work backstage as a first option and review existing licensing regulations.</p> |
| <p>IX. Housing and Support Services Workgroup Update</p> | <p>Don Chamberlain reported that the Housing and Support Work Group has met three times. The group has agreed to meet weekly until February. It is taking a look at the definition that the Department has in contracts and elsewhere and try to recast in light of where Department is trying to go. Examples: Group Homes that operated 24/7 and serve unique individualized populations, specific subsets of clients or four or five clients in a complex that operates like a group home but is categorized as something else.</p> <p>By next week, information on the workgroup should be posted on the DHHS web site with minutes and meeting schedule.</p> |
| <p>X. Contract Compliance Template</p> | <p>Marya Faust distributed an Agreement Review Checklist/template. She said that the template seeks to address two issues: assure that OAMHS has good stewardship of taxpayer’s money and reviews contracts and have some way to assure that contract reports are submitted in a timely fashion. OAMHS and Purchased Services will meet with the provider at least annually to discuss compliance with the agreement as well as areas of non-compliance. The document will continue to be modified to improve its usefulness. Licensing review and corrected action plan would be captured here. Concentrate on what is needed in contract. Submit comments/thoughts to Elaine Ecker at the Muskie School, eecker@usm.maine.edu.</p> <p>Question: Regarding the requirement to have a consumer on the board of directors: what is the definition of consumer? Does it matter if person is served by public or private mental health system or is diagnosed with severe mental illness? Answer: Consumer on board requirement applies to nonprofit agencies that just provide mental health services. Does not apply to hospitals or for profits. Consumer is one who has received services from the agency in the past or who is self-identified as a consumer.</p> <p>Comment: Concerned that agencies required to have just one consumer on their board; can be overpowering to consumers, suggest that the number be changed to two so buddy system could be in place and back up provided. Response: Would hope that agencies would be sensitive to that; contracts need to assume at least one consumer.</p> <p>Don said that OAMHS would like to conduct one contract review per year and eventually have two reviews per year to focus and highlight what issues providers are facing so the Department knows how to make changes on both sides of the coin.</p> <p>In Region I, these meetings will take place on Feb 26 and 27. Carlton Lewis will get a memo out to agencies regarding these dates.</p> <p>Initial meetings will focus on those with larger services; lower priority on those with MaineCare seed only/or contract outpatient providers. They may not be reached in this first round.</p> |

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| | <p>Question: What does the annual review cover? Answer: Generic meeting with agencies around contract.</p> |
| <p>XI. Beds: Crisis Stabilization/Observation</p> | <p>Don Chamberlain said that OAMHS would also like to have this discussion/conversation in January. He directed participants attention to the “Persons Experiencing Psychiatric Crises: Specific Actions” section of the Consent Decree Plan, pages 37-38, Tab 1 of the reference binder. He asked participants to think about what needs to be done regarding crisis stabilization units, outpatient observation beds, acuity and whether resources are located in the right areas. It would be helpful, he said, if those with crisis bed services bring information on their occupancy to the January meeting.</p> |
| <p>XII. Statewide Policy Council</p> | <p>Ron reviewed the tasks of the Statewide Policy Council, listed under Tab 5 in the reference binder. He explained that the process originally outlined to fill this council had grown to include more categories, producing an unworkable number of representatives (49, plus staff). He asked the group for their suggestions on how to achieve a more reasonable number, noting that all the CSNs will make suggestions for OAMHS consideration. He also stated that the timeline for convening the council has been pushed back to March.</p> <p>Ron suggested two ideas discussed at other CSNs: 1) electing three people at large to represent the CSNs, or 2) have a core person who attends each month and brings other members, as necessary, with expertise related to particular agenda items under discussion.</p> <p>Suggestions from group:</p> <ul style="list-style-type: none"> • Pool hospital representation in a variety of configurations, i.e., one possibility: one state, one specialty, one community. • Have state associations for various professions/disciplines send representatives. • Have people represent entire CSN, not just a particular industry in CSN. • Create small specialty groups that feed recommendations to statewide group. <p>Ron thanked the group for its suggestions, said they would be taken under advisement, and that OAMHS would have a proposal to discuss by January.</p> |
| <p>XIII. Ongoing Meeting Schedule</p> | <p>Carlton Lewis asked if members wanted ITV meetings. No one requested ITV. Regarding the ongoing CSN meeting schedule, members agreed that the third Friday of the month is generally the best date.</p> |
| <p>XIV. Agenda for January Meeting</p> | <ul style="list-style-type: none"> • Procedure and Protocols for Inpatient Admissions • Rapid Response and Crisis Plans • Representation to the Statewide Policy Council • Crisis Stabilization Beds/Observation Beds <p>Members questioned whether they should bring information on agenda item 1. Ron said that the agenda would be clarified and gotten out in advance of the January 22nd meeting.</p> |